GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 16, 2022

Hope Lovell
LoveJoy Special Needs Center Corporation
17101 Dolores St
Livonia, MI 48152

RE: License #: AS820294204
Investigation #: 2023A0575005
Dolores Residential Care

Dear Ms. Lovell:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On November 9, 2022, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

Please review the enclosed documentation for accuracy and contact me with any questions. If I am not available, and you need to speak to someone immediately, please contact the local office at (517) 284-9720.

Sincerely,

Jeffrey J. Bozsik, Licensing Consultant
Bureau of Community and Health Systems
(734) 417-4277

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS820294204
Investigation #:	2023A0575005
Complaint Receipt Date:	11/02/2022
Investigation Initiation Date:	11/2/2023
Report Due Date:	12/02/2022
Licensee Name:	LoveJoy Special Needs Center Corporation
Licensee Address:	17101 Dolores St Livonia, MI 48152
Licensee Telephone #:	(517) 574-4693
Administrator:	Hope Lovell, Designee
Licensee Designee:	Hope Lovell, Designee
Name of Facility:	Dolores Residential Care
Facility Address:	17101 Dolores St. Livonia, MI 48152
Facility Telephone #:	(734) 469-4019
Original Issuance Date:	04/07/2008
License **Status:**	REGULAR
Effective Date:	08/14/2021
Expiration Date:	08/13/2023
Capacity:	6
Program Type:	PH; DD; MI; TBI

II. ALLEGATION(S)

	Violation Established?
Residents A and B were assaulted by Resident C.	Yes

III. METHODOLOGY

11/02/2022 11/02/2022	Special Investigation Intake-2023A0575005 Special Investigation Initiated- On site
11/09/2022	Inspection Completed On-site-interviews with (a) Residents A, B, and C; and (b) staffs Latonya Wilson, Jasmine Smith, and Heidi Morton
11/09/2022	Contact - Telephone call made- (a) Daman Watkins- Guardian for Residents A and B; (b) Kathy Hollis-Resident C's guardian; (c) Hope Lovell-licensee designee, and (d) the complainant.
11/09/2022	Corrective Action Plan Requested and Due on 11/09/2022
11/09/2022	Corrective Action Plan Received
11/09/2022	Corrective Action Plan Approved
11/09/2022	Exit Conference-with Hope Lovell, licensee designee

ALLEGATION:

Residents A and B were assaulted by Resident C

INVESTIGATION:

On 11/9/2022, I interviewed Residents A, B, and C. All three residents are developmentally disabled and cognitively impaired. Residents A and B are non-verbal. I viewed Residents A and B's injuries, which were scratches/abrasions to the back of their necks. Resident C admitted to assaulting Resident B.

On 11/9/2022, I interviewed staffs Latonya Wilson and Jasmine Smith, who were on duty on the day (10/31/2022) of the alleged assault. They both stated they did not witness the alleged assault. Staff Heidi Morton stated she was not on duty/at the facility on the day of the incident.

On 11/9/2022, I interviewed the two guardians for the three residents. Guardian Daman Watkins stated he was satisfied with the placement and services Residents A and B are receiving. Guardian Kathy Hollis stated she was satisfied with Resident C's placement, but her guardianship expired, so she was unsure if she was still responsible for Resident C.

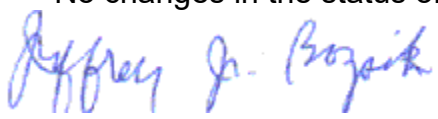
On 11/9/2022, I contacted the complainant. He's a local police officer and was satisfied with the result of the investigation.

On 11/9/2022, I conducted an exit conference with licensee designee, Hope Lovell. She agreed to request a 1:1 staff from Wayne Center for Resident C and concomitantly issue Resident C a 30-day discharge notice, so that if Wayne Center does not approve the 1:1 staffing request, Resident C will need to be relocated to protect the residents of this facility.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Since the preponderance of evidence is that Residents A and B were assaulted by Resident C, then the licensee did not ensure that Residents A and B were treated with dignity and their personal needs, including protection and safety, were not attended to at all times.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable plan of correction has been received; therefore, I recommend No changes in the status of the license.



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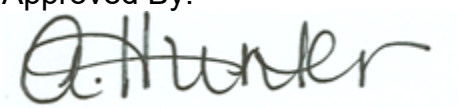
Jeffrey J. Bozsik
Licensing Consultant

Date: 11/9/2022

Approved By:



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Ardra Hunter
Area Manager

Date: 11/16/2022